TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-0896-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 7, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $85.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim … is in the Texas Star Network. … Although pharmacies are not subject to out of network requirements, Texas Mutual indicated in its EOB that the medication was not prescribed by or at the direction of the network treating doctor."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2015	Prescription Medication (Famotidine)	$85.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.021 establishes entitlement to medical benefits.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-165 – Referral absent or exceeded.
   - 855 – Medications not prescribed by or at the direction of the treating doctor as required by DWC rule.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 891 – No additional payment after reconsideration.

Issues

Are the insurance carrier's reasons for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason codes CAC-165 – "REFERRAL ABSENT OR EXCEEDED," and 855 – "MEDICATIONS NOT PRESCRIBED BY OR AT THE DIRECTION OF THE TREATING DOCTOR AS REQUIRED BY DWC RULE." Texas Labor Code §408.021(c) requires that "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor." Review of the submitted information does not support that the disputed service was provided by or referred by the employee's treating doctor. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Even though all the evidence was not discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	January 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.